3. Functions shall include the following: Selecting qualified students, providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and education problems; and assigning and supervising students.

**6.74 General Administrative Services (GAM)**

(a) The functions of the General Administrative Services (GAM) are as follows:

1. General Administrative Services shall be those services associated with the overall direction and administration of the institution at all levels that are not readily distinguishable between inpatient and outpatient services. Expenses and revenues directly associable with services not related to patient care (e.g., data processing services sold to outside organizations administrative personnel responsible for the operation of skilled nursing facilities, and other exclusions) should be reported as reconciliations. Detailed reporting of certain Administrative Service expenses shall be provided.

2. General Administrative Services include:

i. Governing Board;



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ii. Office of hospital Administrator Medical Administration;

iii. Medical Administration;

iv. Nursing Administration (persons responsible for more than one functional center);

v. Personnel;

vi. Public Relations;

vii. Communications;

viii. Management Engineering;

ix. Health Sciences Library;

x. Auxiliary Groups;

xi. Data Processing;

xii. Purchasing and Stores;

xiii. Internal Audit;

xiv. Postage;

xv. Medical Library;

xvi. Medical Photography and Illustration;

xvii. Licenses and Taxes (other than income taxes and payroll taxes);

xviii. Insurance (other than Malpractice and Employees Fringe Benefits);

xix. Security;

xx. Planning;

xxi. Professional Association Memberships;

xxii. Legal and Audit Fees;

xxiii. Duplicating and Printing;

xxiv. Financial Administration;

xxv. Motor Pool; and

xxvi. Travel.

6.75 Inpatient Administrative Services (IAM)

(a) The functions of the Inpatient Administrative Services (IAM) are as follows:

1. Inpatient Administrative Services shall be those primarily associated with the overall direction and administration of inpatient services provided in the institution. For example, the hospital admitting office would be assigned to Inpatient Administrative Services, rather than General Administrative Services. Detailed reporting of certain Administrative Services expenses shall be provided.

6.76 Malpractice Insurance (MAL)

(a) The functions of the Malpractice Insurance (MAL) are as follows:

1. Malpractice Insurance shall include the institution's total premium or self-insurance cost for hospital and professional liability coverage. No other type of insurance coverage shall be included here.

6.77 Employee Health Insurance (EHI)

(a) The functions of the Employee Health Insurance (EHI) are as follows:

1. Employee Health Insurance shall include all premium payments and associated costs with union or group health insurance for employees. Hospitals which are self-insured for employees health insurance shall report no insurance costs in this cost center. However, deductions from operating revenue for personnel health programs shall be reported by cost center.

6.78 Repairs and Maintenance (RPM)

(a) The functions of the Repairs and Maintenance (RPM) are as follows:

1. The Repairs and Maintenance center shall be responsible for maintenance and operation of an institution's buildings and equipment in a state of readiness required to perform hospital operations. Repairs and Maintenance of physical plant not used for services related to patient care (e.g., rental of apartments) shall be reported as reconciliations. Renovation of capital assets is to be distinguished from Repairs and Maintenance Expenses and capitalized with the asset according to the criteria described in section 6.19.

2. The maintenance and repair of specialized equipment in areas such

as Diagnostic Radiology, Therapeutic Radiology, or Laboratory shall report such costs in those centers. Bio-medical engineers shall be treated in this manner.

3. Functions shall include the following: All maintenance of buildings and plant equipment including painting; maintenance of moveable equipment to the extent done by institution employees; and minor improvements and renovation of buildings and plant equipment.

6.79 Utilities Cost (UTC)

(a) The functions of the Utilities Cost (UTC) are as follows:

1. The center shall be used to account for all utility costs such as electricity, gas, oil, disposal services and water. A breakdown of the cost and source of these utilities shall be provided.

2. Telephones shall be considered utilities and thus such costs and revenues shall not be reported in this center. Costs associated with utilities provided to buildings and areas not involved in patient care shall be excluded and reported as reconciliations.

## SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

7.1 Diagnosis Related Groups (DRG)

(a) Diagnosis Related Groups (DRG) represent categories of hospital inpatients with similar clinical characteristics and, except for outliers, patients in each DRG can be expected to consume similar amounts of hospital resources. Assignment of a patient to a DRG requires the following information:

1. Principal diagnosis;

2. Secondary diagnosis;

3. Principal and other procedures;

4. Age;

5. Sex;

6. Discharge status;

7. Birthweight (Newborn); and

8. Neonate.

(b) The appropriate definitions are reported here and these are the only definitions allowable for DRG assignment.

1. Principal diagnosis: The condition established after study shall be chiefly responsible for occasioning the admission of a patient to the hospital for care. The principal diagnosis must be coded using the International Classification of Diseases, 9th Revision, with Clinical Modifications (ICD-9-CM).

2. Secondary diagnosis: Conditions that exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay. Diagnoses which have no bearing on the treatment received during a current hospital stay are not appropriate for use in DRG assignment. All secondary diagnoses must be coded using ICD-9-CM.

3. Principal and other procedures: Diagnostic and therapeutic procedures performed during a patient stay. All procedures must be coded using ICD-9-CM.

4. Age: Patient's chronological age at admission in years.

5. Sex: Patient's sex as male or female.

6. Discharge Status: The circumstances under which a patient left the hospital, coded as routine discharge to home, discharged against medical advice, transferred or died.

7. Birthweight: A newborn's weight in grams at birth.

8. Neonate: A newborn under 29 days of age.

(c) Admission: Patient hospitalized for a condition related to a recent spell of illness.

1. Patients who are treated and subsequently admitted through the emergency room shall be considered admitted to the hospital at the time the physician orders the admission. The cause of the admission shall be considered the cause of the emergency room treatment. Therefore the course of treatment shall be considered one admission. Services rendered in the emergency room shall be reflected in the inpatient record and the UB-82 claim form.

2. Similarly, a patient admitted for a course of treatment as a Same Day Surgery (SDS) patient, who subsequently is admitted from that mode of treatment shall be considered one admission. Services rendered in the SDS mode shall be reflected in the inpatient record and UB-82 claim form.

3. Readmissions are patients admitted to an acute care hospital at another time during the last seven days.

**7.2 Outliers**

(a) Outliers are patients displaying atypical characteristics relative to other patients in a DRG (refer to Sections 5.12(a)2, 5.15(b), and Appendix 1.4 and 1.6). The five (5) categories of outliers are defined below and the methodology for outlier payment is established as follows:

1. Low length of stay (LLOS): Patients assigned to a DRG, but whose length of stay is shorter than the LLOS trim point.

   i. Payment is limited to either the lower of the inlier rate per case or the sum of the acute days multiplied by the LLOS Adjusted Per Diem.

2. High length of stay (HLOS): Patients assigned to a DRG, but whose length of stay is longer than the HLOS trim point.

   i. The Payment is the sum of a) the hospital-specific inlier payment rate per case and b) the hospital-specific HLOS Adjusted Per Diem multiplied by the case-specific total acute days.

3. Transfer patients: Patients under medical advice requiring continued acute care who are transferred from one acute care facility to another acute care facility.

   i. Where a patient's discharge status is that of a transfer to another facility (inpatient), the rate is limited to the lower of the inlier rate per case or the sum of the acute days multiplied by the low outlier per diem. The hospital which received the transfer patient (and that patient is subsequently a non-transfer status discharge) will receive the appropriate rate per case or per diem based upon DRG assignment and trim point status.

4. The base payment rates for DRGs with no base year experience will be calculated using the base year statewide average Medicaid rates for all DRGs.

5. Adjustment in payment for hospital services to children under 6 years of age: Qualifying hospitals that provided services to children that have not reached the age of 6 years and have received payment for those services will receive an additional payment if they meet all of the conditions in i., below.

   i. The following criteria must be met for the above services to be eligible for additional reimbursement:

      (1) The hospital provides its inpatient services within the State;

      (2) The services were provided to a Medicaid-eligible child under the age of 6 years;

      (3) Medicaid was the sole payor of the services provided;

      (4) The acute days billed did not include cut back days; and

(5) The cost of the specific admission exceeds the Medicaid payment by 5 times.

ii. The payment adjustment is 10% of the hospital's unreimbursed cost in providing the specific eligible service.

(1) Beginning with the year ending December 31, 1993, this adjustment will be paid no earlier than 22 months after the calendar year end using the audited Medicaid Final Settlement from the Medicare cost report and 24 months of settlement data.

iii. As used in this section:

(1) Unreimbursed cost is the difference between the State calculated cost for a service less the Medicaid payments made to the hospital for that service;

(2) State Calculated Cost is derived by applying a hospital's Inpatient Cost-to-Charge Ratio before TEFRA to a hospital's Inpatient Claim Charges;

(3) The hospital's Inpatient Cost-to-Charge Ratio before TEFRA is computed as follows:

(A) The numerator is the audited Medicaid inpatient cost before TEFRA using the Medicaid Final Settlement from the Medicare cost report and 24 months of settlement data;

(B) The denominator is the Total Medicaid Inpatient Claim Charges using the audited Medicaid Final Settlement from the Medicare cost report and 24 months of settlement data.

(4) A hospital's Inpatient Claim Charges are those charges appearing on a hospital bill for a specific service provided to a Medicaid child;

(5) Cutback days are the difference between the days billed and the days allowed for a service.